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BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **LAURA MARIA GARCIA** **1220 North Millwood Lane** **Anaheim Hills, CA 92807** **Registered Nurse License No. 532039** **Public Health Nurse Certificate No. 74751** Respondent.	Case No. 2013-28 **ACCUSATION**

Complainant alleges:

PARTIES

1. Louise R. Bailey, M.Ed., RN (Complainant) brings this Accusation solely in her official capacity as the Interim Executive Officer of the Board of Registered Nursing, Department of Consumer Affairs.

2. On or about May 1, 1997, the Board of Registered Nursing issued Registered Nurse License Number 532039 to Laura Maria Garcia (Respondent). The Registered Nurse License was in full force and effect at all times relevant to the charges brought herein and will expire on July 31, 2014, unless renewed.

3. On or about February 10, 2009, the Board of Registered Nursing issued Public Health Nurse Certificate No. 74751 to Respondent. The Public Health Nurse Certificate was in full force

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and effect at all times relevant to the charges brought herein and will expire on July 31, 2014, unless renewed.

JURISDICTION

4 This Accusation is brought before the Board of Registered Nursing (Board), Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

5. Section 2764 of the Code provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license. Under section 2811(b) of the Code, the Board may renew an expired license at any time within eight years after the expiration.

STATUTORY PROVISIONS

6. Section 2750 of the Business and Professions Code (Code) provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

7. 3. Section 2761 of the Code states:

> The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:
>
> (a) Unprofessional conduct, which includes, but is not limited to, the following:
>
> "(1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions in the business or profession for which the license was issued.
>
> . . . .

8. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

FACTS

9. On or about January 14, 2009, Patient A, an 87-year old female was admitted to St. Jude's Medical Center through the Emergency Department with a suspicion of oral Diltiazem

overdose (30 pills). She had a history of Alzheimer's and Parkinson's diseases. Upon admission, her heart rate was in the 20s and her systolic blood pressure was in the 40-60 range. Patient A was transferred to the Intensive Care Unit. Over the course of the next few days, Patient A developed multiple organ failure and was placed on end-of-life/comfort care.

10. On January 17, 2009, Patient A was under the care of Respondent. At around 1200 the vasopressor medications were weaned off. Her vital signs were documented throughout the day, with a heart rate in the 50s beats per minute range, respiratory rate of 7-9 breaths per minute, and her systolic blood pressure was in the 80-90 range. There is no documentation of patient discomfort or distress

11. There were multiple changes made to the Patient Controlled Analgesia device (PCA) which was delivering the morphine to the patient via an intravenous route. At 1656 hours, the PCA was increased to 4ml per hour. At 1701 hours, Respondent documented that the Morphine and Versed were each at 6ml per hour, with no physician order for this adjustment. At 1739 hours, a new syringe was withdrawn and installed. At 1754 hours, Respondent documented a morphine bolus of 20 mg per MD order was given. Twenty minutes later at 1808 hours the patient expired.

12. Respondent documented a verbal order from Dr. Tran as "can increase morphine PCA for comfort and there is no maximum." Per hospital policy, verbal orders are not taken unless under emergent circumstances. Furthermore, hospital policy requires a beginning dosage and end dosage must be provided in a verbal order.

13. The nursing notes do not reflect a conversation with the physician regarding this change nor do they reflect a need for the change due to the patient's discomfort.

14. Hospital policy at St. Jude's Hospital for patient controlled analgesia is that the dose must be re-evaluated if the respiratory rate is less than 10 and that two RNs must validate the prescription in four circumstances: 1) at the pump initiation; 2) when there is a change in order; 3) when there is a medication refill;, and 4) at change of the shift. There is no documentation of this in the patient's chart.

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15. Respondent documented in the chart "per Dr. Tran," however no orders are present in the chart. Morphine doses were adjusted without a physician's order and the order was not verified by two RNs.

16. During interviews Respondent admitted that she did not know how to document appropriately, or how to program the PCA. She also admitted that she increased the patient's dose of morphine without a written physician's order.

17. The coroner's report documents the cause of Patient A's death as Acute Morphine Intoxication.

CAUSE FOR DISCIPLINE

(Unprofessional Conduct - Incompetence)

18. Respondent is subject to disciplinary action under section 2761(a)(l) in that Respondent displayed unprofessional conduct for incompetence in carrying out her usual licensed nursing functions as a Registered and Public Health nurse in her care and treatment of Patient A. as set forth below:

a. Respondent administered medication to a patient without a written doctor's order under non-emergent conditions;

b. When Respondent did not understand how to program the PCA machine she failed to obtain appropriate help to insure accuracy; and

c. Respondent failed to perform a two nurse verification of the change in dosage of morphine.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number 532039, issued to Laura Maria Garcia;

2. Revoking or suspending Public Health Certificate No. 74751, issued to Laura Maria Garcia;

3 Ordering Laura Maria Garcia to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3;

2. Taking such other and further action as deemed necessary and proper.

DATED: July 10, 2012

for LOUISE R. BAILEY, M.ED., RN
Interim Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

SD2012703228